United States Court of Appeals

for the Second Circuit



APPELLANT'S APPENDIX

Signed

76-4014

IN THE UNITED STATES COURT OF APPEALS

FOR THE SECOND CIRCUIT

ALFRED R. TURECAMO and FRANCES M. TURECAMO,

Appellees

v.

COMMISSIONER OF INTERNAL REVENUE,

Appellant

B
P/S

ON APPEAL FROM THE DECISION OF THE

UNITED STATES TAX COURT

APPENDIX

SCOTT P. CRAMPTON,
Assistant Attorney General.

GILBERT E. ANDREWS,
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Tax Division,
Department of Justice,
Washington, D.C. 20530.

UNITED STATES COURT OF APPEALS
FILED
APR 21 1976
SECOND CIRCUIT

PAGINATION AS IN ORIGINAL COPY

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UNITED STATES TAX COURT
GENERAL DOCKET

DOCKET NO. 5441-72

(CAP. AMD. 9/25/72)

Turecamo
ALFRED H. ~~TURECAMO~~ AND FRANCES M. ~~TURECAMO~~
49-17 Douglaston Parkway
Douglaston, N.Y. 11362

PETITIONER.

VS.

COMMISSIONER OF INTERNAL REVENUE.

RESPONDENT.

APPEARANCES FOR PETITIONER:

NAME

ADDRESS

Date Month	Day	Year	Filings and Proceedings	Action	Served
June	30,	1972	PETITION FILED: FEE PAID August 21, 1972		July 26, 1972
July	25,	1972	ORDER TO SHOW CAUSE for failure to file proper petition and pay filing fee due August 25, 1972 or hearing at Washington, D.C. September 6, 1972.		July 25, 1972
Aug.	31,	1972	FILING FEE received		
August	31,	1972	AMENDED PETITION filed.		Sept. 15, 1972
Aug. 31, 1972 Sept.	6,	1972	REQUEST by Petr. for trial at New York, N.Y. filed - HRG. at Wash. D.C. before Judge Drennen	GRANTED Sept. 6, 1972	Sept. 15, 1972
			ORDER to show cause - continued to Oct. 4, 1972		
Sept.	6,	1972	ORDERED that the hrg. on Court's order July 25, 1972 is continued to Oct. 4, 1972 Wash. D.C. to allow respondent time within which to file with the court copy of notice of deficiency.		Sept. 15, 1972
Sept.	20,	1972	Copy of Notice of Deficiency filed.		
Sept.	26,	1972	ORDER, that Court's order dated July 25, 1972 is discharged and case is stricken from the motions session on October 4, 1972 at Washington, D. C.; and further ORDER amending caption.		Sept. 26, 1972
Oct.	19,	1972	ORDER, amending the name in Court's order dated Sept. 26, 1972 by striking and inserting the correct name of Turecamo".		Nov. 3, 1972

(Continued to page 2)

Form No. 4
May 1970

DOCKET NO. 5111-72 (Continuation)

PETITIONER ALFRED V. AND FRANCES M. DURSCHMID — PAGE 2

Date (Month Day Year)	Filings and Proceedings	Action	Served
Nov. 21, 1972	ANSWER TO PETITION AS AMENDED		Nov. 24, 1972
Jan. 14, 1974	NOTICE OF TRIAL on April 16, 1974 at New York, N.Y.		Jan. 14, 1974
Apr. 16, 1974	TRIAL at New York, N.Y. before Judge Scott.		
	Stip. of Facts filed.		
	Original briefs due -- May 31, 1974		
	Reply briefs due -- July 1, 1974		
	UNDER SUBMISSION - JUDGE SCOTT		
May 3, 1974	TRANSCRIPT of April 16, 1974 rec'd.		
May 24, 1974	MOTION by Resp. to extend time to July 1, 1974 within which to file Original Brief. (No Obj. Petr.)	GRANTED May 28, 1974	MAY 29 1974
June 26, 1974	MOTION by Petr. to extend time to September 1, 1974 within which to file Brief. (No Obj. Resp.)	GRANTED June 26, 1974	JUN 27 1974
July 2, 1974	BRIEF for Respondent filed.		SEP 4 1974
Sept. 3, 1974	BRIEF FOR Petitioner filed. (Postmark timely)		SEP 4 1974
Oct. 1, 1974	REPLY BRIEF for Respondent filed.		OCT 3 1974
Oct.2,1974	REPLY BRIEF for Petr. filed. (timely postmarked)		OCT 3 1974
July 30, 1975	FINDINGS OF FACT & OPINION filed Judge Scott.		JUL 30 1975
	(Decision will be entered for Petitioners.)		
July 31, 1975	DECISION entered, Judge Scott.		July 31, 1975
	APPELLATE PROCEEDINGS		
Oct. 28, 1975	NOTICE OF APPEAL to U.S.C.A., 2nd Cir., filed by Resp.		Oct. 29, 1975
Oct. 29, 1975	NOTICE of Filing with copy of notice of appeal mailed to Petrs.		Oct. 29, 1975
Oct. 29, 1975	NOTICE, to parties, of assembling and date for transmission of record.		Oct. 29, 1975
Nov. 11, 1975	MOTION by Resp. for extension of time for transmission of record to Jan. 26, 1976, "No Obj." by Petrs.	GRANTED Nov. 12, 1975	Nov. 12, 1975

GPO 900.390

(Continued to page 3)

UNITED STATES TAX COURT
GENERAL DOCKET

DOCKET NO. 5441-72 (Continuation)

PETITIONER: ALFRED H. AND FRANCES M. TURECAMO (TURECAMO) | PAGE 3

Date (Month Day Year)	Filings and Proceedings	Action	Served
Nov. 12, 1975	NOTICE, to parties, of assembling and extension of date for transmission of record.		Nov. 12, 1975

GPO 857-0-626-973

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UNITED STATES TAX COURT

ALFRED H & FRANCES TUZECAMO
Petitioner(s)

v.

COMMISSIONER OF INTERNAL REVENUE
Respondent

Docket No. 5441-72

AMENDED
PETITION

1. Petitioner (s) request (s) the Court to redetermine the tax deficiency (ies) for the year (s) 1970, as set forth in the notice of deficiency, a copy of which is attached. The notice was issued by the Office of the Internal Revenue Service at New York City, New York.
(City and State)

2. Petitioner (s) taxpayer identification (e. g. social security) number (s) is (~~xxx~~) 082-18-6966.

3. Petitioner (s) make (s) the following claims as to his tax liability:

Year	Amount of Deficiency Disputed	Amount of Addition to Tax, if any, Disputed	Amount of Overpayment Claimed
1970	$1,043.48		

T.C. Form a-S
(Oct. 1970)
Page 1

PLEASE REMOVE CARBONS BEFORE MAILING

4. The Commissioner of Internal Revenue made the following errors in determining this (these) tax deficiency (ies):

a. The commissioner erred in disallowing dependency deductions for 1970

b. The commissioner erred in disallowing medical and dental expenses

c. The commissioner erred in disallowing Casualty loss

5. Petitioner (s) assert (s) the following facts to support the assignment (s) of error (s) set out in paragraph 4. (In your own words, describe fully the facts in support of your claim; use additional pages if necessary):

a. Petitioners aged parent resided with them. Petitioners provided over half of her support

b. Petitioners submitted verification of medical and dental expenses but were not granted pending result of tax court decision

c. Petitioner did not present proof of sustained loss

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Petitioner (s) request (s) that the proceedings in this case be conducted as a "small tax case" under section 7463 of the Internal Revenue Code of 1954, as amended, and Rule 36 of the Rules of Practice of the United States Tax Court.* (See note below).

Alfred H. Tuscano — 49-17 Douglaston Pkwy, Douglaston, N.Y. 11362
Signature of Petitioner (Husband) — Present Address

Frances M. Tuscano — Same.
Signature of Petitioner (Wife) — Present Address
(If joint return was filed)

Signature and address of counsel, if retained by petitioner(s)

* If you do not want to make this request, you should strike out the paragraph at the top of the page. In considering whether to request that the proceedings in this case be conducted as a "small tax case," your attention is called to the following provisions of section 7463:

(a) In General.--In the case of any petition filed with the Tax Court for a redetermination of a deficiency where neither the amount of the deficiency placed in dispute, nor the amount of any claimed overpayment, exceeds--

(1) $1,000 for any one taxable year, in the case of the taxes imposed by subtitle A [Income taxes] and chapter 12 [Gift Tax], or

(2) $1,000, in the case of the tax imposed by chapter 11 [Estate Tax],

at the option of the taxpayer concurred in by the Tax Court or a division thereof before the hearing of the case, proceedings in the case shall be conducted under this section.***

(b) Finality of Decisions.--A decision entered in any case in which the proceedings are conducted under this section shall not be reviewed in any other court and shall not be treated as a precedent for any other case.

* * * * * * * * *

PLEASE REMOVE CARBONS BEFORE MAILING

UNITED STATES TAX COURT

ALFRED H. TURECAMO and FRANCES M. TURECAMO, Petitioners,	)	
v.	)	Docket No. 5441-72
COMMISSIONER OF INTERNAL REVENUE, Respondent.	)	[Filed November 21, 1972]

ANSWER TO PETITION, AS AMENDED

THE RESPONDENT, in answer to the petition, as amended, admits and denies as follows:

1. Admits the allegations of paragraph 1 of the petition, as amended, except denies that a copy of the notice of deficiency was attached to the petition, as amended, and alleges that a copy of the notice of deficiency has been filed with the United States Tax Court pursuant to its Order dated September 6, 1972.

2. and 3. Admits the allegations of paragraphs 2 and 3 of the petition, as amended.

4. a., b. and c. Denies that respondent erred as alleged in subparagraphs a., b. and c. of paragraph 4 of the petition, as amended.

5. a., b. and c. Denies the allegations of subparagraphs a., b. and c. of paragraph 5 of the petition, as amended.

6. Denies generally each and every allegation of the petition, as amended, not hereinbefore specifically admitted, qualified or denied.

WHEREFORE, it is prayed that the deficiency determined by the respondent be in all respects approved.

(Sgd) LEE H. HENKEL, JR. - EHH

LEE H. HENKEL, JR.
Chief Counsel
Internal Revenue Service

OF COUNSEL:

MARVIN E. HAGEN
Regional Counsel
L. WILLIAM FISHMAN
Attorney
Internal Revenue Service
26 Federal Plaza, 12th Floor
New York, New York 10007

UNITED STATES TAX COURT

ALFRED H. TURECAMO, ET UX Petitioner vs COMMISSIONER OF INTERNAL REVENUE Respondent	DOCKET NO. 5441-72

LOCATION OF HEARING: UNITED STATES TAX COURT
NEW YORK, NEW YORK

DATE: April 16, 1974

BEFORE: THE HONORABLE IRENE F. SCOTT

APPEARANCES: ALFRED H .TURECAMO
for the Petitioners
L. WILLIAM FISHMAN
for the Respondent

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OPENING STATEMENT ON BEHALF OF THE RESPONDENT

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EVIDENCE ON BEHALF OF THE PETITIONERS

Witnesses

NAME	DIRECT	CROSS	REDIRECT	RECROSS
Alfred H. Turecamo (Pro se)	18	25		

EVIDENCE ON BEHALF OF THE RESPONDENT

Witnesses

NAME	DIRECT	CROSS	REDIRECT	RECROSS
Lester Gray	28	37		

(Pro se)

EXHIBITS

Joint

Number	Description	Ident	Evid
1-A-2-B	Stipulation of facts	2	2

Tape 4
gv

P R O C E E D I N G S

THE CLERK: Docket number 5441-72, Alfred H. Turecamo, and Francis M. Turecamo, gentlemen for the record may we have your appearances, please?

MR. TURECAMO: Alfred H. Turecamo, T-u-r-e-c-a-m-o.

MR. FISHMAN: L. William Fishman for the Respondent.

THE COURT: All right, Mr. Turecamo, as I understand it, there was a disallowance of a dependency exemption, disallowance of medical and dental expenses, and a disallowance of a casulty loss, is that what's involved?

MR. TURECAMO: Yes, Your Honor.

THE COURT: All right, now do you gentlemen have a stipulation?

MR. FISHMAN: Yes, we do, Your Honor.

THE COURT: All right.

MR. FISHMAN: With Exhibits 1-A and 2-B attached thereto, which at this time I would like to submit to the Court.

THE COURT: All right, the stipulation together with Exhibits 1-A and 2-B is received.

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(Whereupon, the above mentioned documents, were marked for

identification as Joint Exhibits 1-A, and 2-B, and received into evidence.)

MR. FISHMAN: Your Honor, important thing which I would like to suggest to the Court before it is submitted is the fact that as Your Honor will note, the Petitioner Frances M. Turecamo is not in the Court this morning, and -- or at the present time, and Mr. Alfred N. Turecamo, the other Petitioner signed for the Petitioner Frances M. Turecamo.

THE COURT: All right, well --

MR. FISHMAN: And initialed it --

THE COURT: You are her husband?

MR. TURECAMO: Yes.

THE COURT: And, these are basically your expenses?

MR. TURECAMO: Yes.

THE COURT: Well, that's all right.

MR. FISHMAN: Thank you, Your Honor.

THE COURT: All right, now that has been received, now, do you want to make any further opening statement?

MR. TURECAMO: I would like to make a statement.

THE COURT: All right, go right ahead.

MR. TURECAMO: Can I explain the -- the entire story --

THE COURT: Any thing that you want to say.

MR. TURECAMO: Your Honor, in good faith I accepted or in my mother-in-law as a dependent in my home, in the latter part of 1969. Sometime in May of 1970, toward the latter part of May she unfortunately fell and fractured her hip. She was admitted to Manhasek (phonetics) Medical Center at which time they performed an operation, and while she was there she was having considerable problems and pain. She stayed there for about 2 or 3 weeks, and she was transferred to a nursing home. In the hospital she developed complications, as a result of the operation, and she required nursing services, which we paid for.

We found after a month or so at the nursing home that we had to put her back in the hospital, and she went to Long Island Jewish Hospital, and there they removed the pin from her hip, and were treating her at the hospital for several months. She had Staph infections, she had open sores on her body. They had to remove the pin which meant that she couldn't walk anymore, and again the doctors told us that she had to have nursing services.

Unfortunately, as a result of this accident she passed away in the latter part of the year, sometime in December.

The complaint that I have is that in 1970 I claimed my mother-in-law as a dependent. I expended somewhere in the neighborhood of $3500.00 --

THE COURT: It is stipulated that you expended $3531.00 for hospital and nursing care for Mrs. Capenella (phonetics).

MR. TURECAMO: Yes.

THE COURT: And, her own social security was only $1140.00, so I take it this is purely a legal issue of whether the Medicare payments afforded her support, is that right?

MR. TURECAMO: That's --

MR. FISHMAN: That's exactly right, Your Honor.

THE COURT: And, I plain don't know, have we ever had that issue before?

MR. FISHMAN: Not specifically, Your Honor, no not the nature of the Medicare payments which were received in this case.

THE COURT: Because it is obvious -- well, now let me ask you something, let me ask you, you do agree that the only -- the only source of funds that she had other than what this Petitioner furnished her and Medicare furnished her was this $1140.00?

MR. FISHMAN: To my knowledge that is correct.

THE COURT: Well, are you going to stipulate that, otherwise he will have to testify to it?

MR. FISHMAN: I believe that we can stipulate to it.

THE COURT: Well, then you stipulate that her only source of funds other than the Medicare payment, if they are considered a source of funds was $1140.00?

MR. FISHMAN: I believe that we can so stipulate.

THE COURT: Well, you do so stipulate?

MR. FISHMAN: Yes..

THE COURT: All right, now, that makes it clear as a bell that you are entitled to her as a dependent, if the Medicare payments don't count. Now, if these $10,000.00 of Medicare payments count as part of her support, you certainly don't argue that you paid as much as -- as $11,000.00 for her care?

MR. TURECAMO: Yes, I agree, and we stipulated -- we agreed in the stipulation that I could not in any matter of form match the payments that were made by Medicare for her medical expenses.

THE COURT: All right, then that issue is just a legal issue and I will have to research it. And, I don't know which way it will go. I know that -- I know some of the cases that deal with welfare payments, and -- and things of that kind, and how they go, but I have never had Medicare before.

MR. TURECAMO: Well, Your Honor, it seems really unfair and inequitable that an individual could take on the obligation of a dependent and assume this responsibility,

and then have something happen, and then find out a year later, or two years later that the dependency is disclaimed on that basis. It traps an individual into a situation, and I feel that the ruling that --

THE COURT: Well, I agree with you that if the law is that you don't get her it is harsh, but that may be the law, I just don't know.

MR. TURECAMO: Well, is it the law, or it just an arbitrary ruling by the INternal Revenue Service?

THE COURT: Well, it is not -- it is a question not of whether it is -- it is whether the Courts have interpreted the statute to include this type of payment as part of her support.

Now, if it has been consistently interpreted by our Court and higher Courts that way, then that is the way that it is.

MR. TURECAMO: Well, one of the reasons why we had taken this problem -- this far, is that evidently there was no precident that would establish this type of thing.

THE COURT: Well, then it is up to me to consider it and do the best that I can with it in the light of the law.

MR. TURECAMO: It would seem, Your Honor, that --

THE COURT: So, you make whatever argument -- well, I tell you, you make whatever argument you want to

make now, but I will also let you file some form of brief making an argument too.

MR. TURECAMO: Okay, I just, you know, feel that -- the fact that she received these medical payments, it appears as though this is an extension of actually medical insurance more or less. The individual does not have the free use of the money. It is specifically for one purpose, for medical expenses only. The INternal Revenue Service ruling 70-371 more or less indicates that in determining the gross income of an individual, the Medicare payments are not includable and yet it seems arbitrary that when determining a dependancy, they claim that these Medicare payments are includable.

Again, I must say that this is really an unfair ruling to trap a person into a situation like this. If Medicare assumed the complete responsibility and they paid for the medical services or the nursing services, I don't think that we would be standing here. But it is -- it is not a marginable sum of money that we are talking about. The expenditure was in the neighborhood of $3531.00, and to me it's a considerable experditure.

I just hope that the Court would render a fair decision, Your Honor.

THE COURT: Now, let me ask one other thing, on this bill that is attached here, where it shows Medicare

paid $10,434.75. It shows a cash deposit of $21.60, that's not -- Senior Care paid $546.00, that I take it was some state organization?

MR. TURECAMO: I really don't know, there probably were other payments made but all the payments you know were not part of the nursing services. I believe --

THE COURT: In other words, they paid the hospital bill with minor exceptions?

MR. TURECAMO: Yes.

THE COURT: And, you paid --

MR. TURECAMO: I paid the --

THE COURT: You paid the nursing services and the -- practically the total $3541.00 was for nursing services.

MR. TURECAMO: Was nursing services, yes, Your Honor.

THE COURT: All right, I understand that now. And, that is your understanding too?

MR. FISHMAN: Yes, Your Honor. I was just going to make the statement that the Respondent's expert witness could clarify what Senior -- Senior Care represents.

THE COURT: Well, he says that he didn't pay that so, it must have been some form of state payment.

MR. TURECAMO: Well, whatever it was, I am not aware of it.

THE COURT: And, of course the other minor payments here, the $18.00 for a television and the $21.60, and -- the $14.00, it really doesn't make any difference who paid --

MR. TURECAMO: No -- no.

THE COURT: Because they are very minor, as compared to the -- the $3500 -- in other words, the Medicare and -- well, you don't really have to worry about the Senior Care, if the Medicare didn't count, he would be entitled to her, certainly if the Medicare and Senior Care he would be entitled to her, whether she paid the other little amounts out of her own funds, or whether you paid, because they are minor. So, I don't know why any evidence is needed on that.

MR. TURECAMO: No, I think that it is conceded that -- and agreed to by both parties, that the question here is a matter of the -- of determining the dependency. We acknowledge -- that the medicare expenses were well over $10,000.00, and the $3531.00 that was stipulated there, was just for the nursing services that were paid by me, and they couldn't match the expenditure that was made by medicare.

Of course there were other expenses, if you start to include the -- the cost of the home and the food that was expended while she was at home, it will bring up that

cost somewhat, but still will not be in the neighborhood of the $10,000.00 or $11,000.00 that was expended.

THE COURT: In other words, you had other expenses when she was in your home, such as food and lodging and so forth?

MR. TURECAMO: Yes, Your Honor, we set aside two rooms for her. She had -- you know, the run of the house, and we bought her clothing and other things. She was -- there was certain entertainment expenses --

THE COURT: Well, she must have spent her $1140.00 for something.

MR. TURECAMO: We didn't even accept anything from her, Your Honor, she --

THE COURT: I know, but I mean she -- you don't think she really -- do you think maybe she put that in the bank and didn't spend it?

MR. TURECAMO: Well, she gave it to her grandchildren, you know, and -- but we didn't accept anything from her while she was living in our home, my home.

THE COURT: Well, actually if you want to testify to that you can.

Now, your next issue then, -- did you have something to say on that, the -- the next one is the -- well, the medical expense deduction ties right in with the dependency.

MR. TURECAMO: I think that that is the whole --

THE COURT: You get it if she is your dependent, and you don't if she isn't?

MR. TURECAMO: Yes.

THE COURT: All right, now the next one is the casualty loss, are you still contesting that?

MR. TURECAMO: I am in the sense Your Honor, that I cannot produce the bill for the -- automobile repairs, I -- I unfortunately had words with this gentleman because he didn't do the rapairs properly, and I have been trying to get a duplicate bill, and I can't get it. He has been promising to send it to me everytime that I call, him, but I think that probably the reason that he hasn't sent it is because I had this argument with him.

THE COURT: Well, you can testify to it. All right, now anything further that you want to say?

MR. TURECAMO: That's it, Your Honor.

THE COURT: All right, let's hear from the Respondent and then we will let you testify.

MR. FISHMAN: Thank you, Your HOnor, L. William Fishman for the Respondent.

Your Honor, a few minutes ago, a couple items were orally stipulated, and I would like to submit those to the Court at this time.

THE COURT: All right.

MR. FISHMAN: First, I personally will try to make it as clear as possible the effect of the first item, the effect that it would have on the case as far as the Respondent's position goes, that being the stipulation that the Medicare benefit payments were pursuant to 42 USC Chapter 7, sub-chapter 18, part (a).

THE COURT: All right, you stipulate that that is what they were pursuant to, I guess that is --

MR. TURECAMO: Yes, Your Honor.

MR. FISHMAN: That being the so-called basic Medicare benefits.

THE COURT: All right, and you so stipulate -- so that's --

MR. FISHMAN: And, secondly, oral stipulation that the Petitioner's contribution to the support of Frances Cavenaur (phonetics), did not exceed such Medicare benefit payments appearing on Exhibit 2-B,as $10,434.75.

THE COURT: Well, he has already agreed to that, and you so stipulate?

MR. TURECAMO: Yes, that's right.

MR. FISHMAN: And, then one last thing to make it perfectly clear, that being it is orally stipulated that the amounts appearing on Exhibit 2-B, the $10,434.75, were received by the hospital in 1970.

THE COURT: Well, I think that the Exhibit itself is self-explanatory on that, but --

MR. FISHMAN: I just wanted to remove any possible question that you might have.

THE COURT: You don't deny -- you agree that they got this Medicare payment during the year 1970?

MR. TURECAMO: I would assume that they did.

THE COURT: All right, then you will stipulate it for the purposes of this case, that they did? Is the answer yes?

MR. TURECAMO: It put a thought in my mind, maybe the payment was delayed to 1971, then what would happen?

THE COURT: Well, it might make a difference, she was admitted in August and discharged in October.

MR. TURECAMO: Perhaps ---

THE COURT: It would be your burden really to show that it was, but -- when was this bill -- oh, this is a copy of it in 1974.

MR. FISHMAN: This was recently prepared, Your Honor, prepared from the bill.

THE COURT: That's right, and they didn't show you when they actually received the payment from Medicare?

MR. FISHMAN: Perhaps the Respondent's expert witness can shed some light on this, Your HOnor --

THE COURT: All right.

MR. FISHMAN: To give the Court an indication of --

THE COURT: Well, you can put him on and let him try.

MR. FISHMAN: We certainly will, Your Honor. It is the Respondent's position that the Medicare benefits received since they were pursuant to 42 USC Chapter 7, sub-chapter 18, part (a), or what we call basic medicare payments, and that they -- that the benefits in that part are financed through the hospital insurance taxes, imposed on employers, employees and the self-employed by Section 1401 (b) and 310 (b) of the Internal Revenue Code in 1954.

This of course is different from part (b) of waid 42 USC chapter 7, sub-chapter 18, in that the supplementary medicare which is under part (b) is financed through monthly premiums paid only by those --

THE COURT: Well, that's surgical isn't it? Isn't the part (b) the surgical payments?

MR. FISHMAN: I don't know if I can answer this -- Your HOnor, specifically. I do know that -- I am confident that the doctor's bills are covered under part (a), of the -- the Respondent's expert witness does know, so it will be brought out --

THE COURT: All right, go right ahead, and say what you want to say.

MR. FISHMAN: As stated in Revenue Ruling 70-341, 1970-2, CB-31, basic Medicare benefits received via or on the behalf of an individual are includable as the individual's own contribution to his support in determining who provided more than one-half of his support. This is so because the amounts paid to finance a hospital insurance benefit are not insurance premiums, rather they are taxes. And, the regulations -- specifically REgulation 1.152-1 (a) (2) (ii) require that benefits received under the Social Security Act be included in the Court computation, and treated as the beneficiary's own support.

It is therefore contended by the Respondent, that since the payments made to or on the behalf of Frances Kavanaugh, during the taxable year 1970, were for basic Medicare benefits, the payments represent an amount which enter into the support computation, and represent Frances Kavanaugh's contribution to her own support.

Since the Petitioners did not support Frances Kavanaugh in a greater amount, more than half of the claimed dependent's support was not contributed by the Petitioners, and they are not entitled to the dependency exemption under Sections 151, 152 of the Internal Revenue Code of 1954.

Since the Respondent determined that the Petitioners did not contribute more than half of the support of Frances Kavanaugh, the medical expenses which the Petitioner

paid for her benefit are not deductible since Frances Kavanaugh was not the Petitioner's dependent, as required by Section 213 (a) (1), of the Internal Revenue Code of 1954.

And, one last comment Your Honor, in regard to something that was mentioned earlier to the extent that such a result as was determined in the statutory notice of deficiency would be harsh if upheld by the Court, I can only suggest that without the Medicare benefits, the Petitioners would have been burdened with the payment of the $10,434.75 expenses of Frances Kavanaugh. Thank you.

THE COURT: All right, now you may come around and be sworn as a witness. And, give your testimony about what you furnished to Mrs. Kavanaugh in addition to the nursing services which have been stipulated and about the casualty loss and whatever else you want.

THE CLERK: Do you solemnly swear that the testimony you are about to give to the Court in this case, shall be the truth, the whole truth, and nothing but the truth, so help you God?

THE WITNESS: I do.

THE CLERK: For the record may we have your name and address?

THE WITNESS: Alfred H. Turecamo, T-u-r-e-c-a-m-o. 49-17 Douglaston Parkway, Douglaston, New York.

A L F R E D H. T U R E C A M O, having been duly sworn in, testified on behalf of the Petitioners, took the stand and testified as follows:

DIRECT EXAMIATION: (Pro se)

THE COURT: Now, you just go ahead and tell me as a witness what you said.

THE WITNESS: Do I have to repeat the statement again?

THE COURT: Oh, no, not the statement, but Mrs. Frances Kavanaugh is your mother-in-law?

THE WITNESS: Yes.

THE COURT: And, sometime prior to the year 1970, she came to live in your home?

THE WITNESS: Yes, Your Honor.

THE COURT: And, during the whole year of 1970 up until her death, at what time?

THE WITNESS: I believe that it was the latter part of November, early December.

THE COURT: At the latter part of November, or early December, 1970 she did reside in your home when she as not in the hospital or the nursing home?

THE WITNESS: Yes.

THE COURT: All right, and, you furnished her in your home -- well, now she was in the hospital -- what for --

THE WITNESS: A complete stay in the hospital --

THE COURT: About two months?

THE WITNESS: No, it was a little more than that, about 4 or 5 months.

THE COURT: All right, about 4 or 5 months of this 11 months she was in the hospital or the nursing home, and the other six or seven months she was in your home?

THE WITNESS: Yes.

THE COURT: And, you furnished her food, lodging?

THE WITNESS: Yes, entertainment, some clothing, -- transportation, she was in her 80's, and she did require periodic -- periodic medical attention. We used to drive her back and forth to the doctors, that was also paid by Medicare.

THE COURT: Do you mean her transportation back and forth --

THE WITNESS: No the transportation we paid.

THE COURT: Oh, but the doctor's bill --

THE WITNESS: The doctor's bill was paid by Medicare.

THE COURT: Um-huh.

THE WITNESS: She had 2 1/2 rooms to herself in the house, and at the beginning of the year we bought her a television set for her own apartment. Actually the rooms

were in a one family home.

THE COURT: Yes, but it was her apartment -- her apartment?

THE WITNESS: Yes. She would have her own area you know in the house, and she -- naturally she ate with us, and like that, but to make her feel as though she had somewhere that she could go to, she had the rooms set aside for her.

She had her own telephone which we paid for, and -- I don't know what the fair rental value of the rooms in the area that I live in, I live in Douglaston, I would assume that if someone went out and rented an apartment of that type in that neighborhood, it would cost anywhere between $200.00 to $250.00 a month.

So, --

THE COURT: And, her food probably would have run $50.00 to $75.00 if she had bought it?

THE WITNESS: Yes.

THE COURT: Um-huh.

THE WITNESS: But, even adding up all the expenses, once a week we used to go out, with the family and have dinner, she you know was always with us, we bought her clothing from time to time, whatever she needed. I would say that probably all of the expenses that -- including the fair rental value of the rooms that she had in the home,

it would probably be about $6,000.00 or $7,000.00 somewhere in that neighborhood. But, again, I say that even with this it's -- it doesn't come near to the expenditure that was made by Medicare.

THE COURT: In other words you think that actual expenses counting the rent probably came to $4,000.00 to $5,000.00, and then you add on your nursing home payment, you might get up to $8,000.00, but that would be the best that you could do?

THE WITNESS: Yes, Your Honor.

THE COURT: All right. Now, that's all that you have to say on the dependency exemption?

THE WITNESS: Yes, Your Honor.

THE COURT: Now, I may ask you if you know, did she have Social Security by virtue of her own work or of her husband's work prior to --

THE WITNESS: I really don't -- I cannot answer, I know that she did -- you know have some form of Social Security, but whether -- her husband was deceased, and I don't know what it really was a result of.

THE COURT: But, anyway she had been drawing Social Security I take it before the Medicare provisions came into the act?

THE WITNESS: Yes, Your Honor.

THE COURT: And, she became eligible for Medicare

when they came into that?

THE WITNESS: Yes.

THE COURT: I have forgotten when it was now, but wasn't it about 1964 or 1965?

MR. GRAY: 1966.

THE COURT: 1966?

MR. GRAY: Yes, ma'am.

THE COURT: So, she -- how old was she in 1966? This was 1970, four years later, she was --

THE WITNESS: In 1970, she was about 81, so in 1966, I would say that she was about 76.

THE COURT: Ah -- 76, at the time that the Medicare provisions came in?

THE WITNESS: Yes.

THE COURT: And, she had been drawing Social Security for a number of years prior to that?

THE WITNESS: I would assume so, yes, because she didn't work. Her husband died -- oh about ten years prior to that. She was on Social Security for some time, at least 10 years anyway.

THE COURT: Prior to 1966?

THE WITNESS: Yes.

THE COURT: All right, now, I guess that's all that you can say on that, what about the casualty loss, if you want to say anything on it?

THE WITNESS: The only thing that I could say, as I mentioned before, Your Honor, I did have an argument with this --

THE COURT: Well, now wait a minute, we have got to begin at the beginning, you -- was it an automobile accident?

THE WITNESS: Yes.

THE COURT: In 1970, when did you have the automobile accident?

THE WITNESS: Actually it really wasn't an accident per se, you know driving along, we -- the damage to the car was done when -- in the parking area of the shopping center in Douglaston.

THE COURT: In other words you had your car parked by somebody who ran into it?

THE WITNESS: Yes, they evidently --

THE COURT: And, they didn't leave you a note?

THE WITNESS: They didn't leave anything at all, so we had it repaired, as I mentioned, the fender and the two doors, and we had it repaired, and it came --

THE COURT: And, you had no insurance?

THE WITNESS: No, I didn't.

THE COURT: You didn't carry --

THE WITNESS: I had no insurance, no.

THE COURT: Collision insurance, as far as your --

damage to your own car was concerned?

THE WITNESS: No, it was not covered by insurance.

THE COURT: By that type of insurance?

THE WITNESS: Yes.

THE COURT: So, you had no insurance to pay this?

THE WITNESS: That's right.

THE COURT: And, so, what was the cost of getting it repaired?

THE WITNESS: It was about $500.00 and some odd dollars. I -- I believe that I claimed $475.00.

THE COURT: You claimed $475.00, and a deduction of $375.00, and the cost of repairing it -- well, tell us what was done to the -- both doors were knocked in?

THE WITNESS: Yes, the front fender and the two doors were damaged.

THE COURT: And, you were charged roughly $500.00 by --

THE WITNESS: $500.00, --

THE COURT: And, of course you could have subpoenaed this man to testify that repaired it, but you yourself know that you paid him the $500.00?

THE WITNESS: Yes, Your Honor.

THE COURT: All right. And, that was altogether that wasn't for things other than the repair -- just damage

-- of this damage done by being hit in the parking lot?

THE WITNESS: No, this was only for the damage that was done, this one incident.

THE COURT: I see. See sometimes you have other little things fixed along with it, but you didn't --

THE WITNESS: No.

THE COURT: This was --

THE WITNESS: This was the one incident.

THE COURT: The $500.00 or roughly $500.00 was for this one damage?

THE WITNESS: Yes, ma'am.

THE COURT: All right. Anything else you want to add?

THE WITNESS: I guess that's about it.

THE COURT: You may cross examine.

MR. FISHMAN: Just a couple of questions, Your Honor.

CROSS EXAMINATION BY

MR. FISHMAN:

Q In regards to the casualty loss when you paid the person you said fixed your car, how did you pay him? In cash or a check?

A I believe that I paid him by check, but I can't find the check. This is the problem that I am having. If I had the check you know, as the other expenses that I had,

there would be no problem.

Q You did show me one check?

A That was for another incident that I didn't declare on my return.

Q But, you cannot find the other check?

A No, I cannot.

MR. FISHMAN: That's all, Your Honor.

THE COURT: Well, I want to ask you one or two other questions. What kind of car was this?

THE WITNESS: A 1966 Chrysler, Your Honor.

THE COURT: And, you have a rough idea of what the value of this 1966 -- when did this accident happen?

THE WITNESS: In 1970, Your Honor.

THE COURT: What time in 1970, did the accident happen?

THE WITNESS: I believe that it was in the summer of 1970, over the summer --

THE COURT: But, during the summer of 1970?

THE WITNESS: Yes. I would say that the car at that time, as it was four years old. It was a Chrysler Newport sedan, it was probably worth -- I paid about $3600.00 for it new, four years, it probably would be worth about $1300.00 or $2,000.00, somewhere in there.

THE COURT: You would say somewhere between $1500.00 and $2,000.00?

THE WITNESS: Yes, Your Honor.

THE COURT: And, I take it in your opinion, it -- after this accident it was worth the $500.00 less, or you wouldn't have paid the $500.00 to have it fixed up?

THE WITNESS: Yes, ma'am.

THE COURT: So that until you had it fixed up from the accident, it would be worth between $1,000.00 and $1,500.00 as compared to the $1500.00 and $2,000.00?

THE WITNESS: That's right.

THE COURT: I have nothing further. Do you have anything further on that?

MR. FISHMAN: No, Your Honor.

THE COURT: Then, if you have nothing further, you are excused as a witness.

(Witness excused.)

THE COURT: Do you have any further witnesses?

MR. TURECAMO: No, Your Honor.

THE COURT: Then, you rest?

MR. TURECAMO: Yes, Your Honor.

THE COURT: All right, now, do you have witnesses?

MR. FISHMAN: Yes, Your Honor, I do have one expert witness, which I would like to call at this time.

THE COURT: All right, would you call him?

MR. FISHMAN: Mr. Lester Gray.

THE CLERK: You do solemnly swear that the testimony

you are about to give to the Court in this case, shall be the truth, the whole truth, and nothing but the truth, so help you God?

THE WITNESS: I do.

THE CLERK: Please take the stand. For the record may we have your name?

THE WITNESS: My name is Lester Gray.

THE CLERK: How do you spell your last name?

THE WITNESS: G-r-a-y-

THE CLERK: And, your address, please?

THE WITNESS: And, I work for the Social Security Administration at 1657 Broadway. That's in Manhattan, New York.

L E S T E R G R A Y, having been duly sworn, took the stand on the behalf of the Respondent, and testified as follows:

DIRECT EXAMINATION BY

MR. FISHMAN:

Q Mr. Gray, you said you presently are employed by the Social Security Administration?

A That's correct.

Q How long have you been so employed?

A It will be 6 years as of June the 29th, of this year.

Q So, that takes us back --your employment goes --

A Until June of 1968.

Q Thank you. In June of 1968, in what position were you employed?

A I was a claims representative with the Social Security Administration.

Q And, what were the functions of a claims representative?

A The functions basically were the taking of applications from beneficiaries or potential beneficiaries -- applications for benefits under the Social Security Act for aged, blind, or disabled -- excuse me, aged, survivor, or disability cases, and as well as dealing with the Medicare law, and post -- what we termed to be post-adjudicated work, change of address, non-receipt of check. It also involved -- it also involved the adjudication claims, gathering of evidence, birth certificates, that sort of thing, death certificates, doctors' reports on disability, etc.

Q And, you mentioned Medicare law?

A That's correct.

Q Were you referring more specifically to --

A Title 18.

Q Title -- pardon me?

A Title 18, under the Social Security Act.

Q Yes, 42 USC -- I'm sorry, Section 1395, the

Medicare provisions.

A I don't recall the Section off-hand, but --

Q I'm sorry, title 18 is the --

A Yes.

Q Social Security Act?

A Yes.

Q Also known as that?

A That's correct.

Q Thank you. And, how long were you in the position of claims representative?

A Until November the 13th, 1972.

Q At which time you --

A At which time I became an operations supervisor.

Q And, what are the functions of an operations supervisor?

A The functions of the operations supervisor are many and varied, as well as dealing with employees in the office, and assuring that the work moves evenly throughout the office, it also involves answering technical questions of other claims representatives and service representatives, and field representatives, technical questions involving the various programs of Social Security including Medicare.

There are other specific assignments that go along with being an operations supervisor such as at one point I was health insurance coordinator for our office, which

essentially entails being the laison between the Social Security Administration and any intermediary or carrier for the Medicare program that is within the geographical area of that particular office. And, the one -- the largest one of course in the nation would be Blue Cross and Blue Shield, located at 2 Park Avenue.

Q As an operations supervisor and also as a health insurance coordinator for the office in which you worked, as with the position of a claims representative, it was -- or was it a substantial part of your job to deal with the Medicare Laws specifically Title 18 of the Social Security Act?

A Yes, it was.

Q And, can you tell the Court what title 18 deals with?

A Title 18 referred to as the Medicare portion of the Social Security Act, deals with Medicare, and there are basically two types of Medicare -- two programs under the Medicare. There is the part A hospitalization which essentially pays for the hospital bills, and if a person should leave a hospital and go to what is termed to be a skilled nursing facility,"nursing home", the part A handles that as well. Also home health visits by a parttime nurse, we would deal with that.

The other part of Medicare, the part B of Medi-

care deals essentially with doctors' bills, and also with supplies and equipment for say the handicapped. That would pay for doctors' bills.

The part A -- the Part A of Medicare, hospitalization essentially is free and clear, in a sense that there was at that time anyway no premium attached to it, whereas with Part B there is a premium, Part B for the doctors' bills, there is a premium and there was a premium then. And, essentially the way that that works -- did you --

Q No, go ahead.

A The way that that worked, is the beneficiary -- well, Medicare pays for 80 percent of the reasonable cost of the doctors' bills, after the deductible for that calendar year has been paid, the deductible being right now, I believe it is $72.00.

THE COURT: It was $50.00, I think --

THE WITNESS: It was $50.00 back then, correct, ma'am.

BY MR. FISHMAN: (Resuming)

Q You say that that is part B?

A That's part B, right.

Q It covers the doctors' bills?

A So that covers doctor bills, and the Medicare paid for 80 percent of the reasonable cost of these doctor bills after this deductible had been paid. So,

the beneficiary is responsible for paying anything that is considered to be an unreasonable cost, plus the 20 percent beyond the 80 percent which the Medicare picks up and of course the deductible.

Q Are there any type of doctor bills covered by part A?

A The -- it is -- generally -- generally not. When you talk about doctors' bills, and Medicare, generally doctors' bill, you see the doctors' bill other while going to his office, or if the doctor comes into the hospital, and the doctor performs an operation on you, the doctor's bill would fall under part B essentially. All right, if the doctor comes into the hospital, he operates on you, you receive a separate bill from this doctor ordinarily, unless he is on the staff of the hospital, and he's an intern at the hospital, but generally the private doctor gives you his own separate bill, and you pay that, and you are reimbursed by Medicare through part B.

Q Thank you. Referring to the distinction that you implied earlier as to part A and part B --

A Um-huh.

Q Under part A, what is the condition or coverage of the beneficiary?

A Under part A.

Q A recipient of Medicare, under part A?

A Okay, when a person -- when a beneficiary -- when a beneficiary enters a hospital, he begins what is called a spell of illness, and Medicare pays for the --

Q I'm sorry --

THE COURT: That's not what he wanted to know, he wanted to know, for instance if I had no Social Security because I never worked under Social Security, would I be covered under part A?

THE WITNESS: Would you be covered under part A. All right, if you never worked under Social Security you would not ordinarily be covered under part A, however the law provides for at this time, at this point in time --

THE COURT: Yes, but it didn't then?

THE WITNESS: All right, at that point in time --

THE COURT: Did it? Let's talk about it then?

THE WITNESS: All right. At that point in time, the law provided for one escape, if you would.

THE COURT: If you were 65 when it went into effect, you could be covered?

THE WITNESS: If you were 65 -- if you were 65, on or before 1967, you need no work under Social Security in order to be entitled for -- entitled to the part A hospitalzation as long as you were either a citizen of the U.S., or you were an alien lawfully admitted for permanent residency, who has resided here for 5 full

continuous and consecutive years.

BY MR. FISHMAN: (Resuming)

Q And,you say that was the law in 1970?

A That was the law. If however you did work under Social Security, and you paid in the amount --the required amount to the Social Security, you were called fully insured, then you would be entitled to the part A.

THE COURT: And, that -- in other words, even though you were not 65, until after 1967, if you were covered by Social Security you would be entitled to the part A whenever you became 65?

THE WITNESS: If you were 65 on or before 1967.

THE COURT: You were covered by -- whether you worked under Social Security or not?

THE WITNESS: That's right.

THE COURT: But, let's say you became 65 in 1969, you would only be covered by the part A, if you were also entitled to Social Security?

THE WITNESS: Well, the law also provided, I really didn't finish that whole -- that whole point --

THE COURT: That's what I wanted to get at.

THE WITNESS: I'm sorry. The law also provides that under the same provision of not working and being entitled on or before 1967, if you were 65, this is called the Deemed provision, the law also says that so as not to

cut everybody out that just misses that, the law also says that if you were 65 any year after 1967, you would need three quarters of coverage under Social Security. In other words, three calendar quarters of work under Social Security, in order to obtain this coverage. So, that for instance if you were 65 in 1967, you don't need any quarters of work under Social Security.

If you were 65 in 1968, you would need three calendar quarters of work. If you were 65 in 1969, you would need six, and in 1970, you would need nine, etc, etc, etc.

THE COURT: And, it goes on up to -- ultimately you would have to have the whole --

THE WITNESS: That's right -- so, essentially right now it is being phased out, that part of it.

BY MR. FISHMAN: (Resuming)

Q Again, a distinction as to part A and part B, do you have any knowledge as to how these programs are funded?

A The part A program is funded by the part A hospitalization program is funded by the FICA Act, the Federal Insurance Contribution Act Tax, known as Social Security tax. Whereas, the part B doctor bill coverage is funded by the -- the Medicare premium that is paid monthly by the beneficiary.

MR. FISHMAN: I have no further questions.

THE COURT: Do you want to ask him any questions?

MR. TURECAMO: Yes, Your Honor.

CROSS EXAMINATION BY

MR. TURECAMO: (Pro se)

Q Mr. Gray, could you tell me whether or not Medicare would pay for nursing services, if Medicare pays for all the medical expenses, do they also pay for the nursing service when they are ordered by a doctor?

A Nursing services -- private duty nursing?

Q Yes.

A Medicare at that time only provided for -- did not provide for full-time nursing duty services. Are you speaking specifically while outside the hospital?

Q No, in -- while -- while the beneficiary was a patient in the hospital?

A If the beneficiary is a patient in the hospital, Medicare pays for the normal nursing services provided, but not for a full-time nurse, they were not provided --

THE COURT: In other words, not the private RN?

THE WITNESS: That's correct.

THE COURT: Even if the doctor orders it?

THE WITNESS: That's correct.

THE COURT: Or private licensed practical nurse either, I guess, if hospitals permit them there?

THE WITNESS: That's correct.

MR. TURECAMO: I would just like to make a comment, Your Honor.

THE COURT: Well, that's all right, I just wanted to get that clear, you go ahead and ask him whatever you want to.

BY MR. TURECAMO: (Resuming)

Q I guess that's the only -- except that I am not sure -- actually, isn't Social Security itself a form of insurance? The entire-- the overall scope of the Social Security -- would --

A It's --

Q Would you say that that is a form of insurance rather than of welfare type of?

A It is certainly not to be confused with a welfare type of a program, a need program. Social Security is a work -- a work-earned program, based upon the work that was done either by you or by your spouse under the Social Security Act. It is not a need program. It is not based upon need. It is a social insurance system.

THE COURT: You can get Medicare if you are a millionaire and you are entitled to it?

THE WITNESS: That's correct.

THE COURT: You don't get it if you are a pauper, if you don't?

THE WITNESS: That's correct. [39]

BY MR. TURECAMO: (Resuming)

Q In a sense then actually every individual is paying for some type of insurance, it's a compulsory type of -- of an old age insurance, isn't that --

A If you--

Q Isn't that correct, as opposed to just being a welfare or Medicaid type of --

A Again, if you work under the Social Security Act, and you pay the Social Security tax, based upon covered employment, this is a -- it is a work oriented insurance program that is provided for.

MR. TURECAMO: Okay, that's the point that I wanted to make, it actually is insurance as opposed to -- I guess that's all that I have.

THE COURT: Anything further?

MR. FISHMAN: No questions, Your Honor.

THE COURT: Well, thank you very much, Mr. Gray for coming over, you are excused.

(Witness excused.)

THE COURT: Do you have any further evidence that you want to offer?

MR. FISHMAN: No, I don't, Your Honor. The Respondent rests.

THE COURT: All right. Well, I tell you let's

have simultaneous briefs and answering briefs on this? Because you may want to make the argument you more or less made in your opening statement in writing to begin with. So, well, we'll just take -- this is -- I'm not going to get a decision out on this in -- you know, on pro se cases, I try to get the decision out within a month or so, and that's the reason that I give the short time for briefs, but I want to have plenty of time to research this, and look into it. And, so I want to take this case out of its normal turn, in other words I'll take it up just as I would if it were a case with an attorney and so forth.

So, I'm going to give you 45 days for opening briefs, and 30 days for reply, because I wouldn't reach this case before then.

Now, will you give those dates, Mr. Clerk?

THE CLERK: Yes, Your Honor, one moment,please. Those dates, Your Honor are May 31, and July 1, 1974.

THE COURT: All right, well, then you have got the dates, gentlemen, May 31 for --

MR. TURECAMO: May I understand what this means, Your Honor, now I submit an initial brief?

THE COURT: Yes, you write a brief --

MR. TURECAMO: In 45 days?

THE COURT: Setting out -- I tell you, I think maybe our rules have a formal brief in it. Do you have a

copy of them?

MR. TURECAMO: I believe that --

THE COURT: But anyway, why don't you get the Government's attorney here to -- to just give you some -- a copy of some brief -- no I don't believe it does, of some brief that has been written in his office, if it is short enough, it won't be much trouble to run it under a photostat, for him to use as a form?

MR. FISHMAN: Right, or if there is a sample brief in the rules, a copy of the rules that Your Honor has, I'm sure that I have that copy in my office --

THE COURT: Well, there isn't one, I don't think, I was looking here -- you know, I didn't realize our forms were now numbered, but -- no, there are a lot of forms, but not of a brief. But just give him a form --

MR. FISHMAN: We will help the Petitioner, Your Honor.

THE COURT: Well, you write what the issue is, and some findings of fact, and then you write your argument. Now, I mainly want your brief for your argument because the facts really aren't in dispute here. What this gentleman, Mr. Gray testified to is right in the law itself. I was glad to have him state it, because it put it in the record, and I thought that for that matter it might be some help for you in writing your brief. But, it is written

right into the -- into the law, so mainly you get out the facts as best you can, and then give me whatever argument you want to make. And, that will be your original brief.

Then, when the Government files its brief, you just write whatever answer you want to write.

MR. TURECAMO: Will I get a copy of it?

THE COURT: You will indeed. All right.

MR .TURECAMO: And, that is by July 1st, is that right?

THE COURT: Well, the reply by July 1st, the original brief by May 31. And, now that concludes the trial, and this case will be reached and decided in its ordinary course and we will take a short recess before we call the case we had for call at 4:00 o'clock this afternoon.

THE CLERK: Rise please.

(Whereupon, the hearing in the above was adjourned at 4:00 as described above.)

UNITED STATES TAX COURT

Certificate of Transcriber

Docket No. 5441-72 Name: Alfred H. Turecamo, et ux

The foregoing pages, numbers 1 through 42 inclusive, are the true, accurate and complete transcript prepared from the verbal recording made by electronic recording by Pat Schlairet on April 16, 1974 in the United States Tax Court located in NEW YORK, NEW YORK, in accordance with the applicable provisions of the current reporting contract of the Court under which I have performed my duties as transcriber.

(Name) GAIL VALLEE

April 30, 1974

(Date)

64 T. C. No. 71

UNITED STATES TAX COURT

ALFRED H. and FRANCES TURECAMO, Petitioners v. COMMISSIONER OF INTERNAL REVENUE, Respondent

Docket No. 5441-72. Filed July 30, 1975.

1. In computing the total support of a person for the purpose of secs. 151 and 152, I.R.C. 1954, payment of hospital costs by Medicare provided for in Part A of Title XVIII of the Social Security Act, as amended, 42 U.S.C. sec. 1395, should not be treated differently from payments of medical or hospital costs as provided for in Part B of Title XVIII of the Social Security Act, as amended, or by private health insurance, and, therefore, following respondent's rulings as to the latter, the medical payments made under Part A are not includable as part of the recipient's total support for purposes of secs. 151 and 152.

2. From the evidence amount of casualty loss determined.

Alfred H. Turecamo, pro se.

L. William Fishman, for the respondent.

SCOTT, Judge: Respondent determined a deficiency in petitioners' income tax for the calendar year 1970 in the amount of $1,043.48.

The issues for decision are:

(1) Whether petitioners contributed more than half of the support of the mother of one of them during the calendar year 1970 so as to be entitled to a dependency exemption for her and a medical expense deduction for medical expenses they paid for her where the total support payments made on her behalf by petitioners were less than her hospital expenses which were paid by medicare allowances.

(2) Whether petitioners are entitled to a deduction for a casualty loss of $375 as a result of damage to their automobile.

FINDINGS OF FACT

Some of the facts have been stipulated and are found accordingly.

Petitioners, husband and wife who resided in Douglaston, New York at the time their petition in this case was filed, filed a joint Federal income tax return for the calendar year 1970 with the district director of internal revenue, Brooklyn District, New York.

Frances Kavanaugh, the mother of Frances Turecamo and the mother-in-law of Alfred H. Turecamo, who was 81 years old during the calendar year 1970, began living with petitioners prior to the beginning of the calendar year 1970. Mrs. Kavanaugh, during the calendar year 1970, received $1,140 in social security benefits. During this year petitioners provided Mrs. Kavanaugh with two and one-half rooms in their home which she used as her apartment. They maintained a telephone in these rooms for Mrs. Kavanaugh's use. During the time that Mrs. Kavanaugh was residing in petitioners' home, they provided her meals which she ate with petitioners' family. They provided the furnishings in Mrs. Kavanaugh's rooms including a television set, some clothing for Mrs. Kavanaugh and occasional entertainment. Mrs. Kavanaugh did not reimburse petitioners for any of the support furnished to her but used the amount she received from social security for her own support as she saw fit. The total amount contributed by petitioners toward Mrs. Kavanaugh's support through the furnishing of an apartment, food, clothing, and entertainment for her was approximately $4,000.

On August 5, 1970, Mrs. Kavanaugh was admitted to the Long Island Jewish Hospital in New Hyde Park, Long Island, New York and was discharged from the hospital on October 9, 1970. Her total hospital charges while she was in the hospital were $11,095.75, of which $10,434.75 was discharged by "Medicare allowances," which benefits were payments which were made pursuant to the provisions of "Part A - Hospital Insurance Benefits for the Aged", 42 U.S.C., Chapter 7, Section 1395c, amending Title XVIII of the Social Security Act.

In addition to hospital costs, Mrs. Kavanaugh's condition required nursing care. During the calendar year 1970, petitioners expended $3,531 for hospital and nursing care for Mrs. Kavanaugh. Mrs. Kavanaugh died in the early part of December 1970.

On their joint Federal income tax return for the calendar year 1970, petitioners claimed a dependency exemption for Mrs. Kavanaugh and claimed $3,531 as deductible medical expenses which they paid on behalf of Mrs. Kavanaugh in the year 1970. The total medical expenses claimed by petitioners amounted to $4,017 from which they subtracted $674 as representing 3 percent of their reported adjusted gross income, leaving a medical expense deduction claimed by them of $3,343.

Respondent in his notice of deficiency disallowed petitioners' claimed dependency exemption for Mrs. Kavanaugh, stating that petitioners had not established that Mrs. Kavanaugh had qualified as their dependent under sections 151 and 152, I.R.C. 1954.[1] Respondent also disallowed petitioners' claimed medical expense deduction of $3,343 with the explanation that it had not been established that this amount was expended for the purposes designated.

In August 1970 petitioners had their 1966 Chrysler Newport sedan automobile, which they had purchased new in 1966 for approximately $3,600, parked in the parking area of the shopping center in Douglaston, New York. Upon returning to the car petitioners found that both doors and one fender on the car had been badly smashed. No note or any other indication was left on the car to show by whom or how the damage was caused. Petitioners had no insurance on the car. They had the car repaired at a cost of between $475 and $500.

Petitioners on their income tax return for the calendar year 1970 claimed a casualty loss deduction of $375.

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[1] All references are to the Internal Revenue Code of 1954.

Respondent in his notice of deficiency disallowed the claimed $375 casualty loss which petitioners claimed as resulting from damage to their automobile, stating that it had not been established that any deductible loss had been sustained.

OPINION

Respondent's primary position is that the amounts paid as basic Medicare benefits under Part A. -- "Hospital Insurance Benefits for the Aged" of the Social Security Act are in the nature of disbursements made in furtherance of the social welfare objectives of the Federal Government; and, therefore, in determining whether the individual for whom the Medicare benefits are paid is a dependent of another, these payments, though not includable in the gross income of the recipient, should be viewed as amounts paid by the recipient for his own support just as are Social Security benefits. Respondent distinguishes the payments under Part B from those under Part A and states that in his view payments made under Part B are in the nature of health insurance benefit payments and therefore are not a part of the support of the person for whom made.[2]

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[2] Respondent relies primarily on his Rev. Rul. 70-341, 1970-2 C.B. 31, which holds that basic Medicare benefits under Part A of Title XVIII of the Social Security Act as amended (42 U.S.C. sec. 1395), are in the nature of social security payments and are not includable in an

Continued

Petitioners take the position that Medicare payments made on behalf of an individual to a hospital under Part A

Footnote 2-continued

individual's taxable income because of this reason, and that payments under Part B of Title XVIII of the Social Security Act as amended are in the nature of health or accident insurance payments and are not includable in the recipient's income because of the provisions of sec. 104(a), I.R.C. 1954. The revenue ruling then holds that in determining the amount that an individual contributes to his own support for the purpose of ascertaining whether he is the dependent of another person under secs. 151 and 152, I.R.C. 1954, Medicare payments under Part A are considered support furnished by the individual for himself but such payments under Part B are not so considered. In this regard the revenue ruling states:

> With respect to the personal or dependency exemption aspect of this matter, a taxpayer is generally permitted, pursuant to section 151 and section 152 of the Code, to claim a qualified individual as a dependent provided that he furnishes over half of the support of such individual for the year involved. In computing the amount that is contributed to the support of the individual, there must be included any amount that is contributed by such individual for his own support, including amounts that are ordinarily excludable from gross income such as social security payments. For example, Revenue Ruling 57-344, C.B. 1957-2, 112, holds that child insurance benefits under title II of the Social Security Act received and used for the support of a child are considered the child's contribution to his support in determining who furnished more than one-half of the child's support. Likewise, it is held that basic medicare benefits received by (or on behalf of) an individual are includible as the individual's own contribution to his support in determining who provided more than one-half of his support.

Continued

are health benefit insurance payments just as are payments made under Part B or any private insurance program. In support of their position petitioners point to the provisions of section 3101(b) and 3111(b) of the 1954 Revenue Code, both of which are entitled, "Hospital Insurance," the former providing for a tax on the income of every individual equal to stated percentages of his wages, and the latter providing for an excise tax on the employer based on a percentage of his employees' wages and to Title 42, section 1395i (entitled, "Federal Hospital Insurance Trust Fund") of the United States Code which provision is in Part A of subchapter XVIII of the Social Security Act as amended. This section provides for the creation of a "Federal Hospital Insurance Trust Fund" with the amounts received from the taxes imposed by sections 3101(b) and 3111(b) of the Internal Revenue Code.

Footnote 2-continued

> Conversely, supplementary medicare benefits, being in the nature of medical insurance proceeds, are not includible in the support computation of the individual by whom (or on whose behalf) they were received. However, the premiums paid for supplementary medicare coverage are includible in the support computation and are attributable to the person who furnishes the premiums. Revenue Ruling 64-223, C.B. 1964-2,50.

Petitioners further point to the testimony of an expert witness offered by respondent to the effect that the basic Medicare program is not a need or welfare program but a work oriented insurance program provided without regard to means for those persons who qualify for the benefits based on work done either by them or their spouses.

Respondent's argument in summary is that since the basic Medicare benefits provided for under Part A of Title XVIII of the Social Security Act as amended are financed by taxes, which taxes are not stated in section 213(e)[3] to constitute amounts paid for health insurance, benefits received by an individual through payment of hospital costs on his behalf by basic Medicare should be considered a part of his support.

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[3] Secs. 213(a) and 213(e)(1) [I.R.C. 1954] provide as follows:

> (a) Allowance of Deduction.--There shall be allowed as a deduction the following amounts, not compensated for by insurance or otherwise--
>
> (1) the amount by which the amount of the expenses paid during the taxable year (reduced by any amount deductible under paragraph (2)) for medical care of the taxpayer, his spouse, and dependents (as defined in section 152) exceeds 3 percent of the adjusted gross income, and

Continued

Respondent concludes from his ruling (Rev. Rul. 66-216, 1966-2, C.B. 100) that premiums paid by an

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Footnote 3-continued

(2) an amount (not in excess of $150) equal to one-half of the expenses paid during the taxable year for insurance which constitutes medical care for the taxpayer, his spouse, and dependents.

(e) Definitions.--For purposes of this section --

(1) The term "medical care" means amounts paid--

(A) for the diagnosis, cure mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body.

(B) for transportation primarily for and essential to medical care referred to in subparagraph (A), or

(C) for insurance (including amounts paid as premiums under part B of title XVIII of the Social Security Act, relating to supplementary medical insurance for the aged) covering medical care referred to in subparagraphs (A) and (B).

H. Rept. No. 213, to accompany H.R. 6675 (Social Security Amendments of 1965), 89th Cong., 1st Sess. 1965-2 C.B. 733, 742-745, stated as follows:

2. GENERAL REASONS FOR PROVISION

The health care provisions of your committee's bill have a relationship to the medical expense deductions allowed under the Internal Revenue Code. The 3-percent limitation in the case of medical care expenses and the 1-percent limitation applied to expenditures for medicines and drugs were waived for persons 65 or over in recognition of the fact that medical expenses generally constituted

Continued

individual under Part B of Title XVIII of the Social Security Act as amended are part of deductible medical

Footnote 3-continued

a heavy financial burden for older people. The limitations were waived, however, during a period when there was no broad-coverage health insurance plan for older persons. The insurance provisions of your committee's bill are designed to meet these problems. The reasons for the special medical expense provisions in the tax law for the relief of older taxpayers, therefore, no longer appear to exist.

Moreover, restoration of a uniform floor to be applied in the computation of the medical expense deduction will provide an increase in revenue which will help defray to some degree the cost of the general fund of the voluntary insurance provisions in your committee's bill. Only in the case of an older person with sufficient income to be taxable will the benefit of the Federal Government's $36-per-year contribution towards his voluntary medical insurance coverage be reduced or offset by a lesser deduction for medical care expenses. * * *

* * * * * * *

The bill further provides that all taxpayers itemizing their deductions, regardless of age, are to be granted a deduction, without regard to the 3-percent floor, for one-half the cost of medical care insurance for the taxpayer, his spouse, and his dependents, but not to exceed $250. The other half of any premiums paid, plus any excess over the $250 limit for medical care insurance, will continue to be subject to the 3-percent floor and only when they plus any other allowable medical expenses exceed 3 percent of adjusted gross income will they be deductible. Included in the category of medical insurance premiums which may be deducted (one-half under, and one-half apart from, the 3-percent floor) are those for supplementary health insurance benefits for the aged but not the taxes transferred to the trust fund for hospital insurance benefits for the aged.

Continued

expenses under section 213, and it therefore follows that the payments made on behalf of an individual under

Footnote 3-continued

* * * * * * *

> Under the new paragraph (1), subparagraphs (A) and (B) are the same as existing law except for the elimination of the phrase "including amounts paid for accident or health insurance". Under the new subparagraph (C), amounts paid for an insurance contract are included within the definition of medical care only to the extent that the premiums are attributable to insurance covering medical care (as defined in subparagraphs (A) and (B) of section 213(e)(1)). In determining whether a contract constitutes an "insurance" contract, it is irrelevant whether the benefits are payable in cash or services. Under the new paragraph (1)(C), premiums paid under part B of title XVIII of the Social Security Act (relating to supplementary health insurance for the aged) are amounts paid for insurance. Taxes paid under section 1401 (relating to tax on self-employment income) or under section 3101 (relating to tax on income of employees) of the Internal Revenue Code do not constitute amounts paid for insurance.

S. Rept. No. 404, to accompany H.R. 6675 (Social Security Amendments of 1965), 89th Cong., 1st Sess., 1965-2 C.B. 758, 764 contains substantially the same statement as the last paragraph quoted above.

Respondent in Rev. Rul. 66-216, 1966-2 C.B. 100, held, based on the provisions of sec. 213(e), I.R.C. 1954, and the above-quoted legislative history that the payments by an individual under Part B of the Social Security Act as amended are deductible medical expenses but that the taxes collected to finance Part A are not.

Part B are not to be included in the amount furnished by that individual for his own support for the purpose of the dependency exemption provided under sections 151 and 152.[4]

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[4] Respondent relies on his Rev. Rul. 64-223, 1964-2 C.B. 50, 51 in support of his position. After reciting that medical and dental expenses are a part of support of an individual under the provisions of sec. 1.152-1(a)(2)(i), Income Tax Regs., this ruling states:

> (1). Where the taxpayer or the individual is covered under a renewable term policy which provides insurance against the cost of medical care (whether payment is made directly to hospitals and doctors or reimburses the policyholder), the policyholder will be considered as having furnished the care since the policyholder, under a privately financed medical insurance plan, is regarded as providing medical care for himself and the other beneficiaries of the policy. In determining (a) the total amount of support of the individual, and (b) the amount contributed to support by the individual himself or by the taxpayer claiming him as a dependent, the amount paid by the insurance company should be disregarded and only the premiums paid on the policy and the unreimbursed portion of the expenses for medical care should be taken into account.

Section 213(e) of the Code as cited above, indicates that amounts paid for accident or health insurance constitute "medical care." The inclusion in the computation of support of such payments has been recognized by the Tax Court in several cases, although the precise question has never been presented. Lena Hahn, 22 T.C. 212 (1954); Donald Lopez, T.C. Memo 1959-9; James Parker, T.C. Memo 1959-182; William Peery, T.C. Memo 1962-202; John J. Mora, T.C. Memo 1964-122. Recently, the United States District Court for the Northern District of Georgia held in Samples v. United

Continued

We have in a number of cases recognized that medical expense is a part of an individual's support and have

Footnote 4-continued

States, 226 Fed. Supp. 115 (1963) that the benefits received under a health policy must be included in support in determining dependency. The question now presented is whether the premiums paid and the benefits received should be included in support. In considering the question, the Service has reached the conclusion that to include both premiums and benefits in support would in essence be duplication and that the cost of the insurance is the proper amount to be included. Accordingly, the Samples case will not be followed.

(2). Where an individual incurs medical expenses as a result of an automobile accident for which he is reimbursed (i) through insurance carried by the person who is at fault (the tort-feasor) or (ii) directly by the tort-feasor, no part of the amount so paid will enter into the computation of support in determining dependency. The amount paid by the insurance company or the tort-feasor is not considered as support provided by them because this amount is paid in release and satisfaction of a legal claim for an injury to the person of the individual involved and in no way resembles an item of support.

(3). Under the provisions of the Dependents' Medical Care Act of 1956, as amended, 10 U.S.C. 1071, dependents of members of the uniformed services are entitled to receive medical care in medical facilities of the United States Government. The term "uniformed services" means the armed forces and the Commissioned Corps of the Coast and Geodetic Survey and of the Public Health Service. The hospitalization and medical care furnished to the dependent of a member of the uniformed services is furnished because of the member's employment and, therefore, its cost is considered as provided by the member. However, since that member did not incur any expense in connection with the furnishing of such medical services, he is not to be credited with having furnished the dollar value of such services as an item of support in determining dependency under section 152 of the Code.

held premiums paid for medical insurance to be a part of medical expense for support determinations. See Warren C. Mawhinney, 43 T.C. 443 (1965), affirmed per curiam 355 F. 2d 462 (C.A. 3, 1966), in which we listed medical fees, medicines, and health insurance payments, all as part of the support of the taxpayer's children.

In our view it is clear that hospital expenses are medical expenses which form a part of an individual's support. If the expenses are paid and not covered by any form of insurance, there would appear to be no question that the person paying the hospital expense has contributed the amount of the payment to the support of the individual for whom the payment is made. The problem is how should such expenses paid by insurance be treated and should Medicare payments made under Part A be treated as other insurance payments.

We agree with petitioner that no valid basis exists for distinguishing between the hospital insurance benefit payments made under Part A of Title XVIII of the Social Security Act as amended and the medical benefit payments made under Part B of that Act or some form of private insurance policy for determining the total support of an individual for the purposes of sections 151 and 152. The fact that the Part A

benefits are financed by a tax imposed and withheld from the wages of all individuals to whom the tax applies[5] without the necessity of their consent does not distinguish the nature of the payments made under the basic Medicare provisions for hospital benefits from payments made under a program carried voluntarily by an employer for an employee or by an individual voluntarily for himself, either under Part B of Title XVIII of the Social Security Act as amended which is partially financed from the general funds of the Federal Government or with a private insurance company. Part A, as well as Part B, of Title XVIII of the Social Security Act as amended pays benefits only under the conditions specified therein.[6]

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[5] We are aware that when the Medicare provisions first became effective, Part A covered individuals who were already 65, even though they were not entitled to social security benefits. Respondent makes no point of this one-time coverage but relies merely on the distinction he makes of a tax collected to cover the benefit payments as compared to a "voluntary premium payment."

[6] 42 U.S.C., sec. 1395d provides:

§1395d. Scope of benefits

(a) The benefits provided to an individual by the insurance program under this part shall consist of entitlement to have payment made on his behalf or, in the case of payments referred to in section 1395f(d)(2) of this title to him (subject to the provisions of this part) for --

Continued

Private insurance carried for an individual either by his employer or in a private policy carried by the

Footnote 6-continued

(1) inpatient hospital services for up to 150 days during any spell of illness minus 1 day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made);

(2) post-hospital extended care services for up to 100 days during any spell of illness; and

(3) post-hospital home health services for up to 100 visits (during the one-year described in section 1395x(n) of this title) after the beginning of one spell of illness and before the beginning of the next.

Sec. 1395k of 42 U.S.C. provides:

§1395k. Scope of benefits; definitions

(a) The benefits provided to an individual by the insurance program established by this part shall consist of --

(1) entitlement to have payment made to him or on his behalf (subject to the provisions of this part) for medical and other health services, except those described in paragraph (2)(B); and

(2) entitlement to have payment made on his behalf (subject to the provisions of this part) for --

(A) home health services for up to 100 visits during a calendar year;

Continued

individual himself pays benefits only under the contractual conditions specified. The Part A and Part B Medicare provisions, as well as private health insurance contracts, pay only for the risks insured against, which basically are when a hospital or medical treatment is required by an individual. All of these insurance agreements pay for medical costs.

The fact that Congress chose to allow a medical expense deduction under section 213 for the Part B premium payments but not for the tax paid to finance Part A, has no bearing on the nature of the benefits paid when the risk insured against occurs. There is no necessary correlation between section 213 and sections 151 and 152. Likewise, respondent's so-called "duplication" theory of including in support both premium payments for health insurance and the benefits paid by the insurance does not find support in sections 151 and 152. The premiums may well be paid in a different year from that

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Footnote 6-continued

> (B) medical and other health services (other than physicians' services unless furnished by a resident or intern of a hospital and the services for which payment may be made pursuant to section 1395n(b)(2) of this title) furnished by a provider of services or by others under arrangements with them made by a provider of services; and
>
> (C) outpatient physical therapy services.

in which the benefits are received (see section 213(e)(3) allowing deduction for premiums paid for prepaid medical insurance under certain circumstances) and certainly in many instances the benefits received in one year from the insurance often exceed by many times the total of premiums paid for all prior years during which the insurance was carried. Respondent apparently makes no distinction between health benefits furnished by an employer received in a particular year and payments made by a private insurance contract or Part B of Medicare, even though in his Rev. Rul. 64-223, 1964-2 C.B. 50, he holds that since certain employees incur no "cost" from employer furnished medical services, there is no amount to include as support of a dependent from such medical services being available to the dependent from another's employment.

In our view none of the distinctions which respondent attempts to make between benefits paid by Part A Medicare and other forms of health or medical insurance is valid.

Respondent bases his position in this case solely on his distinction between hospital cost payments made under the basic Medicare provisions of Part A of Title XVIII of the Social Security Act as amended and those made under Part B of that Act or a private insurance policy. Since respondent clearly concedes that Part B

or private insurance payments are not includable in determining the support furnished to an individual and we conclude that there is no proper basis for distinguishing these payments from payments made under Part A of Medicare, we will not consider whether all such payments should be included as part of an individual's support. Therefore, we hold that under the facts here present, petitioners contributed over one-half of Mrs. Kavanaugh's support in 1970 and are entitled to their claimed dependency exemption for her and to include the medical expenses they paid for her in computing their medical expense deduction for 1970.

The issue with respect to the casualty loss claimed by petitioners because of damage to their automobile is purely factual. Section 165(c)(3) allows an individual to deduct losses of property not connected with a trade or business if such losses arise from fire, storm, shipwreck, or other casualty, or from theft. Damage to an automobile which occurred while the automobile was parked for a short time in a parking lot has generally been recognized as an "other casualty." Respondent does not contend to the contrary, but rather argues that petitioners have not carried their burden of proof with

respect to the amount of deduction to which they are entitled. Respondent points out that a casualty loss deduction is limited to the lesser of the adjusted basis of the property or the amount by which the fair market value of the property immediately before the casualty exceeds the fair market value of the property immediately after the casualty. Respondent argues that petitioners have failed to show either the fair market value of their automobile before the casualty or after the casualty.

Petitioner Alfred H. Turecamo testified that he paid $3,600 for his automobile, and he estimated that before the casualty the automobile had a fair market value of between $1,200 and $1,500. Petitioner argues that the fair market value of the automobile would be reduced by the casualty by at least the amount required to have the damage repaired. Section 1.165-7(a)(2)(i) and (ii) Income Tax Regs., provides the method of valuation of property involved in a casualty. While providing that generally a competent appraisal must be obtained of the fair market value of the property immediately before and immediately after the casualty, the regulation further states that the cost of repairs to the property damaged is acceptable as evidence of the

loss of value if the taxpayer shows that the repairs are necessary to restore the property to its condition immediately before the casualty; the amount spent for the repairs is not excessive; the repairs do not cover more than the damage suffered; and the value of the property after the repairs does not as a result of the repairs exceed the value of the property immediately before the casualty.

While the evidence in this case is not as strong as might have been desirable, the testimony of Alfred H. Turecamo in our view is in all respects truthful. Petitioners were not represented by counsel. It is clear from the record that petitioners spent between $475 and $500 in repairs to their automobile. Alfred Turecamo also testified that he had an argument with the person who repaired the automobile concerning the quality of the work. Taking the testimony as a whole, in our view, it is sufficient to support a claimed casualty loss of $475 which is deductible to the extent of $375. We therefore sustain petitioners' claimed casualty loss deduction of $375.

Decision will be entered for petitioners.

Reviewed by the Court.

WILBUR, J., concurring: The respondent has ruled that the premiums paid for health insurance, rather than the benefits paid by the insurance plan, are the amounts to be included in support for determining who is entitled to a dependency exemption. Rev. Rul. 64-223, 1964-2 C.B. 50. While a good argument can be made that this position corresponds with the economic realities;[1] the validity of this revenue ruling is not before us and was never an issue in these proceedings. This case was tried and briefed solely on the validity of the Government's position that the hospital insurance benefits of Part A of Title XVIII of the Social Security Act are not insurance, while the supplementary medical insurance benefits of Part B are insurance.[2] The respondent's case must, therefore, stand or fall on his assertion that Part

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1. No prudent man with the means and opportunity to acquire health insurance will fail to do so with the enormous costs of health care today. The average man looks at his health costs as his insurance premiums plus his unreimbursed payments for health care, which accords with the economic realities (and the amount deductible as a medical expense). Viewing large third party payments (made when the contingency insured against occurs) as support can be viewed as distorting the economic realities.

2. References to Part A, Part B, and Part C are to Title XVIII of the Social Security Act, as amended, 42 U.S.C. sec. 1395. Title XVIII was added to the Social Security Act by P.L. 89-97 (1965), 79 Stat. 286.

A is a severable and distinct part of the program of "Health Insurance for the Aged and Disabled" established by Title XVIII (including Parts A, B, and C), and that the severed portion is not insurance.

The Government's position is purely and simply at odds with the history and structure of the program of health insurance for the aged and disabled.[3] The original Committee on Economic Security considered the issue of health insurance for the aged along with Social Security. The report of the Committee sent to Congress on January 17, 1935 discussed general principles and promised further efforts to develop a health insurance plan, but specific recommendations were not included for tactical reasons, although a report was subsequently filed.[4] From the middle thirties to the mid-sixties when the present program was enacted, a series of bills was introduced and reintroduced embodying provisions similar to those found in Part A of Title XVIII.[5] These bills were drafted

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3. The disabled were first covered under P.L. 92-603 (1972), 86 Stat. 1329.

4. See Witte, The Development of the Social Security Act (University of Wisconsin Press, 1962); Sydenstricker, Public Health Provisions of the Social Social Act, 3 Law and Contemporary Problems 263, 264 (1936)

5. See for example H.R. 1 and S. 1, 89th Cong., 1st Sess., (King-Anderson bill).

to provide a public health insurance program for the aged. This is in fact what Title XVIII of the Social Security Act accomplishes, by providing an integrated program of inpatient and outpatient benefits that must be looked at as a whole for purposes of the issue we face.

Parts A and B are intertwined and interdependent components of a single comprehensive health insurance plan. Like comprehensive health insurance plans underwritten by private insurers, it provides inpatient hospital services (Part A) and outpatient hospital services (Part B), physicians' services (Part B), care in an extended care facility (Part A), and home health services (both Part A and Part B). Part C (ignored by respondent), provides a common definition of all the critical terms (various providers, services covered, reimbursement methods, etc.) applicable to <u>both</u> Part A and B. For example, a home health agency is defined in section 1861(o) (42 U.S.C. 1395x(o)) and home health services are defined in section 1861(m)(42 U.S.C. 1395x(m)). This definition is applicable whether the services are provided under Part A (within one year of an individual's discharge from a hospital or skilled nursing facility) or under Part B. Similarly a provider--such as a hospital or a home health agency (see section 1861(u), 42 U.S.C. 1395x(u))--is reimbursed on a reasonable cost basis as that term is defined in section 1861(v)(42 U.S.C. 1395x(v)), regardless of whether the services are provided under Part A or Part B.

Similarly, provisions relating to Federal interference in the practice of medicine, free patient choice, and the option to obtain other health insurance (sections 1801, 1802, and 1803, 42 U.S.C. 1395, 1395(a), 1395(b)) are common to both Parts A and B. Sections 1862-1879 (42 U.S.C. 1395y-1395pp) contain a number of provisions common to both Part A and Part B, including inter alia, such basic provisions as exclusions from coverage (section 1862, 42 U.S.C. 1395y), the Health Insurance Benefits Advisory Council or HIBAC (section 1867, 42 U.S.C. 1395dd), Appeals (section 1869, 42 U.S.C. 1395ff), Overpayments (section 1870, 42 U.S.C. 1395gg), Payments to Health Maintenance Organizations or H.M.O's (section 1876, 42 U.S.C. 1395mm), Penalties (section 1877, 42 U.S.C. 1395nn), and Limitations on Beneficiary Liability where "Medicare" claims are disallowed (section 1879, 42 U.S.C. 1395pp). In fact, the very term "Medicare" is commonly used to denote the entire Title XVIII program of comprehensive benefits provided by Parts A, B, and C.

Like Medicare, most comprehensive health plans can be divided into two aspects, the provisions relating to inpatient hospital services and those relating to physician's services and other health services provided on an outpatient basis. The latter are generally subject to a deductible

and coinsurance factor to net out administrative expenses attributable to small claims and to provide cost disincentives to overutilization. Indeed, the two major plans offered to Federal employees under the Federal Employees Health Benefits Act of 1959,[6] after which major features of the Medicare program were patterned, contain these characteristics.[7] In recognition of the similarity of Medicare to private health insurance plans, claims

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[6] 73 Stat. 708, (5 U.S.C. 8904).

[7] That the annual deductible (currently $60) and the 20 percent coinsurance attributable to medical care on an outpatient basis is very similar to the two major high option plans offered to Federal employees by private insurers is no surprise, since Medicare was patterned after these plans. An alternative to Medicare considered by Congress in 1965 was explained by its sponsor as follows:

> The substitute adopts the approach used by the private insurance industry and it is patterned after the system of insurance that we have provided for our own Federal employees. The benefits are patterned on the high option of the Government-wide indemnity contract negotiated between the Civil Service Commission and private carriers for the benefit of Federal employees. 111 Cong. Rec. 7220 (1965) (Remarks of Mr. Byrnes).

The floor manager of the bill that became Medicare stated that, with regard to health insurance, the substitute bill incorporated "everything that is within the Committee bill except with respect to the one matter of how do we finance the cost of taking care of this problem." 111 Cong. Rec. 7213 (1965) (Remarks of Mr. Mills).

administration was delegated to private insurance companies (carriers and fiscal intermediaries) to utilize their on-going experience with very similar health insurance plans.

It is true that these two features of Medicare are financed through different trust funds and different revenue sources, the trust fund revenue for Part A resulting from payroll taxes on employers, employees and the self-employed (as well as some general revenue financing for gratuitous wage credits provided certain military personnel), and the trust fund revenues for Part B coming one-half from premium contributions made by enrollees and one-half from general Federal revenues. But this financing disparity, resulting from the historical development of the legislation within Congress in 1965 and associated political exigencies,[8] does not obscure the insurance character of

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8. There was a desire to use both general revenue and payroll tax financing; the latter to enable individuals to prepay during their working years the costs of hospital expenses in their later years, which was thought to represent the major health costs of the elderly. Additionally, it was felt that physicians would be less apprehensive of Government interference if their fees were not paid from payroll taxes. Also, Part B, as developed within the Congress, enabled physicians to be reimbursed on the basis of reasonable charges--the physicians' customary charge limited by that prevailing in the locality for similar services. (The current provisions, somewhat modified since 1965, are found in secs. 1833(a)(1), 1395 1(a), and 42 U.S.C. 1842(b)(3), 1395u(b)(3)). See 111 Cong. Rec. 7213, 7214 (1965) (Remarks of Mr. Mills). The development of the bill is briefly recounted in Manley, The Politics of Finance (Little, Brown 1970), p. 118-121.

the system: pooling of risks; specified benefits payable on specified contingencies; benefits payable as a matter of right to those in an insured status; and contributions imposed in accordance with actuarial methods designed to insure actuarial soundness. An integrated public health insurance program, modeled after those made available by the private sector, should not be fragmented into its component fragments any more than the private prototypes.

Respondent nevertheless asks us to treat the comprehensive health insurance plan provided by Medicare as two distinct and separate plans--Parts A and B (ignoring Part C), and declare that Part A is not insurance. For the reasons stated above, the program cannot be looked at in fragmented components for purposes of the issue presented in this case.

Even if we accepted respondent's attempt to sever Part A from the integrated program provided by Title XVIII, he errs in characterizing Part A as social "welfare" rather than insurance. Respondent bases his refusal to recognize Part A as insurance (while admitting that Part B is insurance) on three factors: (1) Part A is, like the cash benefits program established by Title II of the Social Security Act, a social "welfare" program;[9] (2) Part A is a compulsory

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[9] Respondent vastly oversimplifies this program. See Meyers, Social Insurance and Allied Government Programs (Irwin 1965), p. 8. See also Meyers, Medicare (Irwin 1970), p. 87.

program financed by a payroll tax, while Part B is a voluntary program financed by general revenues and contributions made by electing participants; (3) payroll taxes paid for health insurance are not deductible as medical expenses under section 213 of the Internal Revenue Code of 1954 while the contributions made by those participating in Part B are deductible under that section. None of these distinctions are valid.

The decisions respondent cites holding that welfare benefits--either cash or in the form of medical assistance--are includible in determining support (see Helen M. Lutter, 61 T.C. 685 (1974), aff'd per curiam _____F. 2d _____ (7th Cir., Apr. 28, 1975, 35 AFTR 2d 75-1414, 75-1 U.S.T.C. Par. 9439) are clearly irrelevant to the issue herein presented. Lutter involved cash payments pursuant to the program of Aid to Families with Dependent Children (A.F.D.C) established by Title IV of the Social Security Act. This is a welfare program entirely different from the insurance programs established by Title II and Title XVIII of the Social Security Act. A.F.D.C. is a welfare program for needy families with dependent children (sections 401, 42 U.S.C. 601, and 402(a), 42 U.S.C. 602), and

can only be paid in accordance with need standards established by each state in accordance with general provisions included in the Federal law (see section 402(a)(7) and (8), 42 U.S.C. 602(a)(7)(8)).

Lutter also involved payments of medical assistance pursuant to the Federal-state matching programs established by Title XIX of the Social Security Act, (42 U.S.C. 1396). These payments can only be made to individuals already receiving a cash grant under one of the applicable public assistance programs (such as A.F.D.C. which is based on need) and to certain medically needy individuals who need help with their medical expenses, but not their basic living expenses. (Section 1902(a)(10), 42 U.S.C. 1396a(a)(10)). Again, for the latter group, the states must establish need standards in accordance with general criteria in the Federal law (section 1902(a)(17), 42 U.S.C. 1396a(a)(17)) and their need standards must be related to those used to establish eligibility for cash grants (section 1903(f), 42 U.S.C. 1396b(f)).

There is no need standard imposed in determining eligibility for either Social Security or Medicare. The wealthiest man qualifies for benefits if he meets the

insurance requirements; the poorest individual is ineligible if he fails to meet the insurance requirements.[10]

Anyone with a passing acquaintance with health insurance for the aged knows that the whole program was designed to avoid a means test that was applicable to the existing program for medical assistance to the medically indigent elderly. Respondent confuses the concept of social welfare underlying a portion of the cash benefit formula in the Social Security program established by Title II, and in a non sequitur, attempts to characterize Part A of Title XVIII (as fragmented from its related parts) as welfare. It is true that the benefit structure for cash payments is based on principles of individual equity and social adequacy.[11] While benefits are wage related to provide individual equity, the benefit formula is weighted, a minimum benefit is provided, and benefits are provided for certain dependent relatives (such as a wife and dependent children) to insure social adequacy. These concepts do not destroy the insurance

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10. There were transitory provisions in 1965 covering those who did not have an opportunity to meet the insurance requirements because of their advanced age, but these provisions were not based on any standard of need and respondent does not make an issue of these provisions in this case.

11. See Meyers, Social Insurance and Allied Government Programs (Irwin 1965) pp. 25, 26.

character of cash benefits under Social Security.[12] Even if they did, they have much less relevance to the hospital insurance benefits provided by Part A, wherein each beneficiary receives the actuarial value of the insurance protection provided, rather than a cash benefit that varies greatly as between individuals. Individuals who are not covered under Part A can now elect coverage for a premium contribution that is currently a flat rate of $40 per month.[13] The numerous variations in benefits based on social adequacy in the cash program is simply not applicable to the hospital insurance protection provided by Part A of Title XVIII.

Respondent's analogy of the hospital insurance program to Social Security cash benefits is wrong for an additional reason. It is clear that annuity income--whether from a private annuity or Social Security--is included in

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12. Benefits are still paid as a matter of right to individuals in an insured status and the benefit formula is wage related. See section 215 (42 U.S.C. 415); Meyers, supra, n. 9 at p. 36.

13. See 39 Fed. Reg. 45309 (1974).

an individual's support if expended for that purpose.[14] For these reasons cases involving the inclusion of Social Security benefits--or any other annuity income--in support for purposes of determining dependency are not relevant to the issue at hand. We are here concerned not with an annuity, but health insurance benefits, and respondent attempts to distinguish benefits provided under a private health insurance program from benefits provided under a public health insurance program for purposes of determining support. It is this distinction we are confronted with and the distinction is without validity for the purposes of determining support under the income tax laws.

Respondent next argues that Part A is not insurance because it is a "compulsory" program, (while Part B is voluntary). This distinction is without legal merit.

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14. It is a mystery why respondent identifies Part A of Title XVIII with the Social Security cash benefits provided by Title II (rather than with Part B of Title XVIII) to reach this result. In the very ruling he relies on he also clearly states that "neither the basic Medicare benefits nor the supplementary Medicare benefits qualify as a 'pension or annuity.'" Rev. Rul. 70-341, 1970-2 C.B. 31, 32. (emphasis supplied). Respondent in this quotation recognizes that Title XVIII is in its entirety a health insurance program as distinguished from the annuity program provided under Title II.

An insurance program does not lose its insurance character simply because participation is compulsory. Even if this were true, the distinction respondent makes between Parts A and B with regard to freedom of choice to participate is more illusory than real. An individual is not required to accept hospital benefits under Part A (section 1814(a)(1), 42 U.S.C. 1395f(a)(1)) and may purchase alternative or supplemental health insurance, if available (section 1803, 42 U.S.C. 1395b). An individual who declines Part A benefits is nevertheless required to pay the hospital insurance tax while foregoing the benefits provided. But this situation is analogous in some respects to Part B. Whether an individual elects the Part B coverage or not he will, as a general taxpayer, be required to underwrite the 50 percent of the program costs provided from general Federal revenues. An individual will be paying taxes to provide approximately half of the costs of both programs--Part A through the employee's tax on his covered wages and Part B primarily through the individual income tax, whether or not he participates in either program.

Additionally, when a person reaches 65 and is eligible for hospital and related insurance benefits under Part A, he is virtually compelled to take Part B. It is impossible to find a commercially available plan equivalent to Part B for a competitive premium since the Federal Government is paying one-half of the premium costs of Part B. Additionally,

the law presumes that an eligible individual elects Part B coverage,[15] and premiums are automatically withheld from his Social Security or Railroad Retirement benefits (section 1840(a) and (b), 42 U.S.C. 1395s(a)(1) and (2))[16] unless the individual takes affirmative action to elect out of the program. This presumed election, combined with the economic incentives of Government cost sharing and the mechanical simplicity of the withholding of premium payments, has resulted in the participation of virtually all of those eligible for Part B. Indeed, the Congress anticipated that up to 95 percent of the aged eligibles would participate in Part B,[17] and the latest data indicate that this expectation has been fulfilled. The

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15. Section 1837(f) (42 U.S.C. 1395p(f)) provides

> (f) Any individual--
> (1) who is eligible * * *
> (2) * * *
> (3) * * *
>
> shall be deemed to have enrolled in the medical insurance program established by this part.

16. These are the principal sources of wage-replacement income for most of the nation's nearly 30 million aged and disabled.

17. H. Rept. No. 213, 89th Cong., 1st Sess. (1965) p. 3.

compulsion may be economic rather than juridical in Part B, but from an empirical viewpoint, it has approximately the same coercive effect.[18]

Finally, Social Security has traditionally been a compulsory program for several reasons, including a desire to insure that individual workers will have prepaid benefit rights upon reaching retirement age and to guard against "anti-selection." Anti-selection would result if the public program underwrites the poor risks while the better risks seek private insurance protection. These are both factors attributable to the hospital insurance plan established by Title XVIII, which covers the major portion of the health insurance costs of the elderly.[19] Additionally,

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18. The number of aged enrolled in Part B had by July 1974 reached 21.2 million, about 95 percent of the total population aged 65 and over. 1975 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund, House Doc. No. 94-137, 94th Cong., 1st Sess. (1975), p. 2.

19. Part A benefits disbursed from the Hospital Insurance Trust Fund (including administrative expenses) in fiscal year 1974 were $8.1 million; the comparable figure for Part B disbursed from the Supplementary Medical Insurance Trust Fund was $3.3 billion. Compare 1975 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund, House Doc. No. 94-136, 94th Cong., 1st Sess., p. 1, with 1975 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund, House Doc. No. 94-137, 94th Cong., 1st Sess. (1975), p. 1.

continued

the risk of anti-selection in the prepaid Part A program was probably of more concern in the health programs than the cash benefit program in view of the additional actuarial uncertainties the health program presented.[20]

Respondent's reliance on the apparent distinction between the juridical compulsion and empirical compulsion to participate in Part A and Part B is therefore without any substantive significance in resolving the issue before us.

Footnote 19--continued

The manager of the House bill stated during floor debate:

> We picked this single biggest element, namely, the cost of being in a hospital, and we financed that by the payroll tax to let the person during his working years, through small amounts of money paid per week, per month, or per year, make advance payments to that trust fund entirely on his own and from his employer and by the self-employed on their own account. 111 Cong. Rec. 7214 (1965) (Remarks of Mr. Mills).

20. See H. Rept. No. 213, 89th Cong., 1st Sess. (1965), p. 47. The factor of anti-selection in the Part B program was dealt with by empirical compulsion. The program was structured to integrate with the Part A program as a unitary whole, so that virtually everyone was expected to follow his own economic interests (particularly in view of the economic compulsion imposed through financial incentives) and elect coverage. Additionally, the law included safeguards for anti-selection under Part B by providing limited enrollment periods, as well as increased premium contributions for those making a deferred election. (See also Meyers, Medicare (Irwin, 1970) p. 88.) To the extent the voluntary versus compulsory distinction has any meaningful distinction in substance as opposed to form, it is attributable to the manner in which the legislation developed in Congress and tactical political considerations. See notes 7 and 8, supra.

Respondent contends that by not permitting an individual employee to deduct the hospital insurance portion of the tax under section 213 of the Internal Revenue Code of 1954, Congress indicated that the hospital insurance program was not insurance. This ignores the pattern of the legislative history wherein Congress consistently described all of Title XVIII as an insurance program.[21]

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21. Additionally, the problems associated with the tax treatment of premium contributions and benefits under Social Security are considerable to say the least. (See, for example, Tax Reform Studies and Proposals, U.S. Treasury Department, 91st Cong., 1st Sess. (1965) (Joint Committee print of Committee on Ways and Means and Senate Finance Committee), p. 232-234; Goode, The Individual Income Tax, (Brookings 1964 , p. 105-110). Congress may simply not have wanted to open up all of these problems in connection with the Medicare bill, which in itself presented enough problems. One problem that comes immediately to mind is how to treat refunds of taxes where an employee working for multiple employers pays taxes on excess wages, if the hospital insurance tax (as opposed to the remaining payroll tax) were deductible. Additional administrative problems would be presented and Congress, in declining to make the hospital insurance tax deductible, may have been concerned about these as well as the difficulty of explaining to the average man why only a portion of his payroll taxes could be deducted. Finally, Congress provided relief in 1965 to the working individual by permitting him to deduct a portion of his current health insurance premiums without regard to the 3 percent floor contained in sec. 213 of the Code. Sec. 213(a)(2), I.R.C. of 1954. See H. Rept. No. 213, 89th Cong., 1st sess. (1965), p. 138.

Moreover, respondent's reasoning is a non sequitur. The deductibility for tax purposes of the costs incurred in acquiring health insurance coverage does not affect the insurance character of the program provided. The program may (and the hospital insurance program provided by Part A does) provide a wide-spread pooling of risks against specified contingencies; provide various benefits specifically spelled out in the program; provide benefits as a matter of right to those in an insured status; and provide specific contribution rates determined in accordance with actuarial methods calculated to meet the estimated costs of the system. These are the relevant criteria, and whether or not a plan meets them is wholly unrelated to the deductibility for tax purposes of contributions to acquire an insured status.

DAWSON and HALL, JJ., agree with this concurring opinion.

TANNENWALD, J., dissenting: The majority accepts as the starting point of its reasoning respondent's concession that supplementary medical benefits paid under Part B of Title XVIII of the Social Security Act do not count in determining the total amount of "support" for purposes of section 152. See Rev. Rul. 70-341, 1970-2 C.B. 31. Compare Rev. Rul. 64-223, 1964-2 C.B. 50. They then argue that no distinction should be drawn between benefits paid under Part A and Part B. Ergo, the majority concludes that medical benefits paid under Part A should similarly be excluded in determining the amount of total support.

In my opinion, we should not ride piggyback on respondent's concession as to a situation not presently before us, namely, how Part B or private medical insurance benefits for which specific payment is made should be treated. Compare Samples v. United States, 226 F. Supp. 115 (N.D. Ga. 1963), with Rev. Rul. 70-341, supra, and Rev. Rul. 64-223, supra. See also Mawhinney v. Commissioner, 355 F. 2d 462 (C.A. 3, 1966), affg. per curiam 43 T.C. 443 (1965). Respondent's rulings are clearly not binding upon us (see Stubbs, Overbeck & Associates v. United States, 445 F. 2d 1142, 1146-1147

C.A. 5, 1971)) and, whatever force they may have as a reflection of administrative interpretation of a statute available as an aid to construction (see Hanover Bank v. Commissioner, 369 U.S. 672, 686 (1962)), the latter principle should have no bearing herein, where respondent's interpretation relied upon by the majority involves another issue and, indeed, respondent has in fact given the opposite construction with respect to the issue we are called upon to decide. See Rev. Rul. 70-341, supra.

In short, I believe we should address ourselves to the precise questions before us, namely, whether medical insurance benefits paid under Part A are includable in determining the amount of total support and by whom they should be deemed contributed, and resolve those questions within the frame of reference of judicial decisions in comparable situations and without regard to the position respondent has taken in other contexts.

In Helen M. Lutter, 61 T.C. 685 (1974), affd. per curiam ___ F. 2d ____ (C.A. 7, Apr. 28, 1975, 35 AFTR 2d 72-1414, 75-1 USTC par. 9439), benefits received by a mother from the state as "Aid to Families with Dependent

Children" and as medical assistance were held to constitute total support, but not furnished by the mother.[1] We have reached the same conclusion with respect to amounts spent by the Wisconsin State Department of Public Welfare for an invalid child (John L. Donner, Sr., 25 T.C. 1043 (1956)); the cost of support furnished by a state mental hospital;[2] welfare payments actually used for support (Eddie L. Carter, 55 T.C. 109 (1970)); cash grants from a county's Department of Social Services;[3] and hospital services furnished without charge to a claimed dependent.[4] Finally, we have consistently held that social security payments received as old-age and disability insurance benefits and used by the recipient for support constitute self-support.[5]

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1 See also Hiram Johnson, T.C. Memo. 1974-150.

2 H. B. House, T.C. Memo. 1959-47.

3 John A. Frazier, T.C. Memo. 1973-21.

4 Roy B. Abbott, a Memorandum Opinion of this Court dated February 9, 1954.

5 See Thomas J. Black, T.C. Memo. 1972-135, Glenn W. Kincheloe, T.C. Memo. 1971-35, Wilfred Abel, T.C. Memo. 1962-192, and William H. Stand, T.C. Memo. 1960-55.

To my mind, medical benefits under Part A are comparable to the benefits involved in the above-mentioned cases. Accordingly, I would hold that such benefits should be included in the amount of total support and that the amount of such benefits was contributed by the mother for her own support, with the result that petitioners did not furnish more than half of her support and are not entitled to claim her as a dependent for the purposes of sections 152 and 213.

RAUM, SIMPSON, and QUEALY, JJ., agree with this dissent.

UNITED STATES TAX COURT
WASHINGTON

M.
ALFRED H. and FRANCES TURECAMO
Petitioner,

v.

COMMISSIONER OF INTERNAL REVENUE,
Respondent.

Docket No. 5441-72.

D E C I S I O N

Pursuant to the determination of the Court, as set forth in its Findings of Fact and Opinion filed July 30, 1975, it is

ORDERED AND DECIDED: That there is no deficiency due from the petitioners for the taxable year 1970.

Entered: JUL 31 1975

(Signed) IRENE F. SCOTT
Judge.

Decision is correct and in accord with Stipulation, opinion or Rule 50 computation.

(Attorney)

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CERTIFICATE OF SERVICE

It is hereby certified that service of this appendix has been made on the appellees, appearing pro se, by mailing four copies thereof on this 31st day of March, 1976, in an envelope, with postage prepaid, properly addressed to them as follows:

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